United Nations E/CN.9/2012/5

Economic and Social Council

Distr.: General
8 February 2012

Original: English

Commission on Population and Development
Forty-fifth session
23-27 April 2012
Item 3 of the provisional agenda*
Actions in follow-up to the recommendations of the International Conference on Population and Development

Monitoring of population programmes, focusing on adolescents and youth

Report of the Secretary-General

Summary

In accordance with decision 2010/101, by which the Commission on Population and Development adopted "Adolescents and youth" as the theme for its forty-fifth session, the present report provides an overview of development issues related to young people's sexual and reproductive health, with particular emphasis on the needs of girls and young women.

The report reviews actions by Governments, non-governmental organizations and the United Nations Population Fund and its partners that create a supportive environment for young people as they make the transition to adulthood; invest in young people; promote their rights and gender equality; provide access to sexual and reproductive health information and services; encourage their education and social integration; ensure protective measures and safe spaces for the most vulnerable among them, including those in humanitarian situations; and support an enabling policy and legal framework for their participation in policymaking.

The report concludes by drawing attention to further actions required to promote and secure young people's sexual and reproductive health and reproductive rights as a development priority to meet internationally agreed development goals and contribute to countries' broad development aims.

* E/CN.9/2012/2.

12-22713 (E) 060312

Please recycle

Abbreviations

ILO	International Labour Organization
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UN-Women	United Nations Entity for Gender Equality and the Empowerment of Women
WHO	World Health Organization

I. Introduction

1. The present report is submitted in response to decision 2010/101 of the Commission on Population and Development (see E/2010/25-E/CN.9/2010/9), in which the Commission decided to adopt "Adolescents and youth" as the special theme for its forty-fifth session.[1]

2. There are over 1.8 billion young people between the ages of 10 and 24 today, the largest generation of young people in history. Close to 90 per cent of all young people live in developing countries, where they tend to make up a large proportion of the population. In Swaziland, Uganda and Zimbabwe, the proportion is more than 50 per cent, and in 67 other developing countries, young people constitute more than 40 per cent of the population aged 10 years and older.

3. In recent years, countries have made considerable progress in the formulation of national youth policies with the guidance of the World Programme of Action for Youth. Yet many elements of those policies do not have budgets attached to them or result in the mainstreaming of young people's issues in national policy agendas.

4. Some regions, including Central and Eastern Europe and Central Asia, have ensured near-universal primary and secondary education. Elsewhere, especially in sub-Saharan Africa and South Asia, secondary education still remains out of reach for most young people, especially girls. Countries that have managed to expand access to primary education currently face greater demand for secondary education. Ensuring equitable access and quality education remains a challenge.[2]

5. Youth employment likewise remains a challenge. The formal sector offers too few openings, and most young people living in poverty lack the education and skills to take advantage of the opportunities that exist. By the end of 2010, there were about 75.1 million young unemployed people.[3] About 152 million employed youth still live in extreme poverty, doing low-paid and unsafe work.

6. Young people, as much as all people, share the human right to health, including sexual and reproductive health, but there are also compelling policy reasons for investing in young people's health and development.[4] Nearly two thirds of premature deaths and one third of the total disease burden in adults are associated with conditions or behaviours that began in youth.[5]

7. The first study of global patterns of mortality in young people found that 2.6 million young people between the ages of 10 and 24 die every year, 97 per cent of them in low- and middle-income countries. Complications during pregnancy and childbirth, gender-based violence and AIDS are among the leading causes of

---

[1] UNFPA uses the following terms: "adolescents", for 10- to 19-year-olds (early adolescence 10-14; late adolescence 15-19); "youth", for 15- to 24-year-olds; and "young people", for 10- to 24-year-olds. Adolescence and youth are periods of transition to adulthood, but young people are highly diversified by age, sex, marital status, schooling level, residence and socio-economic status, among other factors.

[2] For a detailed discussion, see UNESCO Institute for Statistics, *Global Education Digest 2011: Comparing Education Statistics across the World* (Montreal, 2011).

[3] ILO, *Global Employment Trends for Youth: 2011 Update* (Geneva, 2011).

[4] WHO, *Child and Adolescent Health and Development: Progress Report 2009* (Geneva, 2010).

[5] World Bank, *World Development Report 2007: Development and the Next Generaation* (Washington, D.C., 2006).

mortality for young people.[6] Maternal mortality and morbidity account for 16 per cent of all disability-adjusted life years, the sum of years of potential life lost owing to premature mortality and the years of productive life lost owing to disability, among women aged 15 to 29 in developing countries.[7]

8. Between 2000 and 2009, 31 per cent of young women aged 20 to 24 in least developed countries gave birth before age 18.[8] In low- and middle-income countries, complications from pregnancy continue to be the leading cause of mortality among adolescent girls aged 15 to 19. Most adolescent girls, whether married or unmarried, give birth with insufficient information, health care and support. Among the main risks faced by the youngest mothers are prolonged labour, fistula, post-partum infection, HIV infection and mother-to-child transmission.

9. Adolescent girls and young women face high levels of morbidity and mortality as a result of unsafe abortion. In 2008, there were an estimated 3 million unsafe abortions in developing countries among girls aged 15 to 19.[9] Because many adolescent pregnancies are unintended, rates of unsafe abortion among young women are high, especially in sub-Saharan Africa, where girls aged 15 to 19 account for one in every four unsafe abortions.[10]

10. Unmet need for modern contraception remains at historically high levels, especially in developing countries. Demand will continue to rise because today's young people are entering their reproductive years, and many will wish to have smaller families than their parents had.

11. Limited access to information and to quality and affordable adolescent and youth sexual and reproductive health services is one of the main factors contributing to the high unmet need for contraceptives. An in-depth study of four sub-Saharan African countries found that 60 per cent or more of adolescent men and women did not know how to prevent pregnancy and one third or more did not know of a source for contraceptives.[11]

12. Young people aged 15 to 24 account for 41 per cent of all new HIV infections in the 15 to 49 age group, which means that 3,000 young people are newly infected with HIV every day.[12] Young women are more vulnerable than young men: in Kenya, for example, women aged 15 to 24 are four times more likely to have HIV than males of the same age.[13] Only 34 per cent of youth (24 per cent of young

---

[6] George C. Patton and others, "Global patterns of mortality in young people: a systematic analysis of population health data", *The Lancet*, vol. 374, No. 9693 (2009).

[7] Elizabeth Lule and others, "Adolescent health programs", in *Disease Control Priorities in Developing Countries*, 2nd ed., Dean T. Jamison and others, eds. (New York Oxford University Press; Washington, D.C., World Bank, 2006).

[8] *The State of the World's Children 2011: Adolescence — An Age of Opportunity* (United Nations publication, Sales No. E.11.XX.1).

[9] WHO, *WHO Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes among Adolescents in Developing Countries* (Geneva, 2011).

[10] WHO, *Women and Health: Today's Evidence Tomorrow's Agenda* (Geneva, 2009).

[11] Guttmacher Institute and International Planned Parenthood Federation, "Facts on the sexual and reproductive health of adolescent women in the developing world" (April 2010). Available from www.guttmacher.org/sections/adolescents.php.

[12] UNAIDS, *Global Report: UNAIDS Report on the Global AIDS Epidemic 2010* (Geneva, 2010).

[13] Kenya, National AIDS Control Council, United Nations General Assembly Special Session on HIV and AIDS Country Report (Nairobi, 2010).

women and 36 per cent of young men for low- and middle-income countries) can answer correctly five basic questions about HIV and how to prevent it.[14]

13. Child marriage is a human rights issue in itself, and often involves the denial of many other human rights, including the right to education and health.[15] Most countries have a legally established minimum age of marriage, but the enforcement of laws varies and traditional practice often prevails. Child marriage is still widespread, especially in the least developed countries, where 30 per cent of women aged 15 to 19 are married or in union.[8] If present patterns continue, in the next decade around 100 million girls will be married as children.[16]

14. Across all economic strata and across the world, adolescent girls and young women live under the threat of sexual violence and abuse, including from an intimate partner. Up to 50 per cent of sexual assault cases are committed against girls under age 16. It is estimated that half of the adolescent girls in the Caribbean region are forced into sexual initiation. Central American women also suffer high rates of violence. Studies in sub-Saharan Africa found that the violence of partners and the fear of abuse stopped girls from saying no to sex and jeopardized condom use.[17] In sub-Saharan Africa, young women make up 71 per cent of the young people living with HIV.

15. Female genital mutilation or cutting is still widespread. Between 100 million and 140 million women and girls have experienced female genital mutilation or cutting in Africa.[18] Although the proportion of women undergoing it is decreasing significantly in Burkina Faso, Egypt, Eritrea, Kenya, Nigeria and Senegal, over 3 million girls worldwide remain at risk of the procedure every year.

16. It is estimated that one in every five adolescents experiences a mental health or behavioural problem each year. Gender-based violence increases three- to fourfold the risk of depression and anxiety in adolescents, especially those in emergency settings. Mental health problems often lead to risky behaviours, including unsafe sex, substance abuse and failure to seek care.[19] In low- and middle-income countries, access to mental health services is generally limited, and services that address adolescents' needs are especially inadequate.

17. Overall, young people continue to face poverty, unemployment and underemployment, inadequate education, poor health outcomes and violence. Poor, rural young people, especially girls, are vulnerable to unwanted sexual contact and gender-based violence, including child and forced marriage. They lack access to sexual and reproductive health services to avoid unintended pregnancies, unsafe abortions and sexually transmitted infections, including HIV. The unmet need for

---

[14] UNAIDS, *AIDS at 30: Nations at the Crossroads* (Geneva, 2011).

[15] Using the Convention on the Rights of the Child as a framework, these rights include the right to life, health, education, participation, protection from harmful practices and freedom from abuse and exploitation. It is a violation of article 16, paragraph 2, of the Universal Declaration of Human Rights, which provides that marriage shall be entered into only with the free and full consent of the intending spouses.

[16] International Center for Research on Women, "Child marriage facts and figures". Available from www.icrw.org/child-marriage-facts-and-figures (accessed 26 January 2012).

[17] Population Reference Bureau, "Family planning saves lives", 16 March 2009. Available from www.prb.org.

[18] WHO estimates 2011.

[19] See http://sphhs.gwumc.edu/departments/globalheath/adolescentmentalhealthroundtable.

contraception remains high, and demand is rising. The Programme of Action of the International Conference on Population and Development and the key actions for its further implementation are still an unfinished agenda for young people in most regions of the world.

II. Policies, programmes and participation

18. The sheer size of today's young generation will cause significant population growth in the coming decades, even if each young woman has only two children. However, falling fertility and smaller families will ease the burden of health-care and education costs and release resources for investment. Many countries in Asia and Latin America have already reaped this demographic dividend. Ensuring that this opportunity becomes available in those countries that have not yet done so, notably in South Asia and sub-Saharan Africa, requires appropriate policies and urgent investment in young people. Failure to respond will entrench poverty for generations.

19. As experience shows and research indicates, successful policies are based on enabling young people to make choices and take the lead in encouraging others to do the same.[20] Such a policy framework reflects universal human rights and young people's right to a fair share of national investment. It includes a legal and social environment that respects and encourages young people's evolving capacities for decision-making, removes barriers to gender equality, enables later marriage and combats gender-based violence. Policies investing in the development of the human capital of young people should be complemented by integrated strategies for growth and job creation and the development of specific interventions to reach disadvantaged youth.

20. Policy frameworks should reflect the understanding that poverty, education, sexual and reproductive health and gender equality are linked in complex ways and across generations. For example, poverty is one of the main causes of unequal access to education, creating a compound disadvantage for girls of secondary-school age. Among the poorest household quintile, only 63 per cent of girls attend lower secondary school, compared with 90 per cent of boys from the richest household quintile.[21] Girls' lack of education combined with their already low economic status reduces their autonomy and self-esteem, so they are at enhanced risk for sexual exploitation, sexually transmitted infections, including HIV, unintended pregnancy and gender-based violence. They are likely to remain poor and powerless and to pass on their disadvantages to their children.

21. Attention to young people's rights and needs has been growing but has not always translated into effective investments. In 2010, a review of national poverty reduction strategies showed that three out of four of them did not identify young

---

[20] Judith Bruce and John Bongaarts, "The new population challenge", in *A Pivotal Moment: Population, Justice, and the Environmental Challenge*, Laurie Mazur, ed. (Washington, D.C., Island Press, 2009).

[21] UNESCO, *Global Education Digest 2011* (see footnote 2).

people as a major group experiencing poverty despite evidence to the contrary.[22] Furthermore, only 33 per cent of the strategies involved consulting young people.

22. There are good practices that illustrate meaningful youth participation. Throughout the International Year of Youth, 2010/11, young people mobilized in over 30 countries to put young people's rights at the heart of development. In Latin America, young people are leading efforts to promote the implementation of the Letter of Bahia, an important outcome document for the region from the International Year of Youth. In Africa, youth-led organizations have continued to promote the ratification of the African Youth Charter and the implementation of the Maputo Plan of Action. In Belize, young people host a radio show designed to address issues facing youth in the country, with support from the United Nations country programme. In Honduras, a United Nations inter-agency programme has supported a policy road map for children and youth called Ruta Social para un Buen Gobierno por la Infancia, Adolescencia y Yuventud.

23. In Viet Nam, the population and housing census conducted in 2009 helped to identify marginalized youth groups, which are the current focus of the United Nations country programme and the national policy. Youth-led participatory research has incorporated young people's perspectives in data collection and analysis, for example in Zambia and in Bamyan Province, Afghanistan. Myanmar addressed young people's lack of capacity by developing youth leadership training on health and development. In Nicaragua, Plan International created a diploma course on sexual and reproductive health and governance.

24. Effective laws are essential in creating a supportive environment. For example, in 2010, 102 countries reporting on indicators monitoring the implementation of the Declaration of Commitment on HIV/AIDS had passed non-discrimination laws and regulations protecting young people. They are, however, insufficient by themselves to ensure access. In practice, young people, particularly young women, find frequently that the need for parental or spousal permission, disapproval from the family or the community and negative attitudes among service providers curtail their access to sexual and reproductive health services.

III. Gender equality and investing in adolescent girls

25. The Programme of Action of the International Conference on Population and Development and the key actions for its further implementation highlighted greater equality for the girl child as a right in itself, as well as a necessary first step for women to realize their full potential and become equal partners in development. Investing in girls benefits not only the girls themselves but also their families, communities and countries over many generations. Educated and healthy adolescent girls equipped with life skills will stay in school longer, marry later, delay childbearing, have healthier children and earn higher incomes.[22] Investing in their rights and empowerment will help to accelerate the achievement of internationally agreed development goals, including the Millennium Development Goals.

26. The United Nations Inter-Agency Task Force on Adolescent Girls, which is co-chaired by UNFPA and UNICEF, includes ILO, UNESCO, UNHCR, UN-Women

[22] UNFPA, *The Case for Investing in Young People as Part of a National Poverty Reduction Strategy*, 2nd ed. (New York, 2010).

and WHO and is now joined by more than 20 countries, provides a platform for collective action. Through the Task Force, the United Nations system is promoting a comprehensive evidence-based model that gets girls into school and helps them stay there; guarantees their access to health information and services, including sexual and reproductive health, and gives them control over their life decisions while ensuring their successful transition into adulthood. Particular attention is given to reaching the most marginalized girls.

27. The model was successfully put into practice by UNFPA and the Population Council and its partners in the Berhane Hewan programme in Ethiopia.[23] The programme aims to delay marriage and increase school attendance, while promoting functional literacy and life skills and providing social support, including mentoring, and reproductive health information for married and unmarried girls.[23] A similar approach supported by UNFPA and the Population Council, Abriendo Oportunidades, in Guatemala, is helping to create a cadre of young women advocating for their rights in rural Mayan communities. The programme uses a mapping exercise that reflects girls' own perspectives on health and safety and encourages them to share their ideas about ways to improve health services. Sharing the maps with the community builds local buy-in for girls' programmes.

28. Delaying the age of marriage not only protects girls' rights but can also, under certain circumstances, help offset population momentum and slow down the pace of population growth.[20] Effective interventions include keeping girls in school; providing them with livelihood education; identifying socio-economic alternatives; addressing cultural norms and working with parents; and advocating for policy change, including the enforcement of child marriage laws.[23] In Pakistan, research on vulnerable girls led by UNFPA will be the first step in a joint initiative to help girls affected by harmful practices. It will also ascertain whether those girls can find programmes to help themselves. In Malawi, the work of UNFPA with youth councils on the legal age of marriage has evolved into a United Nations joint programme that reaches out to girls at risk of child marriage.

29. UNFPA and UNICEF work together in supporting communities to put an end to female genital mutilation or cutting. Through partnerships with governments, non-governmental organizations, religious leaders and community groups, in four years, more than 8,000 communities in Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, the Gambia, Guinea, Guinea-Bissau, Kenya, Mali, Mauritania, Senegal and Somalia have abandoned the practice. Those countries are able to change the social norms and cultural practices, and communities are uniting to protect the rights of girls.

30. In Egypt, the United Nations will support a comprehensive model emphasizing the active citizenship and participation of marginalized adolescent girls in their communities. Ishraq is a programme in Upper Egypt, now being scaled up, to improve the health and the social and education opportunities of out-of-school girls. The programme trained teachers, engaged parents, worked with non-governmental organizations and community leaders and established institutional ties with formal schooling systems.

---

[23] Miriam Temin and Ruth Levine, *Start with a Girl: A New Agenda for Global Health* (Washington, D.C., Center for Global Development, 2009).

31. Programmes in Rwanda focus on the empowerment of adolescent girls through sexuality education, particularly on the prevention of HIV infection and unwanted pregnancy. Many schools are providing girls-only toilets and sanitary supplies and designating rooms in boarding schools as solely for girls. Recently, a national vaccination programme against the human papillomavirus reached 97 per cent of adolescent girls.

32. In Liberia, UNFPA led an assessment of the reach of youth-centred programmes, which became a benchmark for holistic multisectoral programming for young people. UNFPA also supported a focused mentorship programme for younger adolescents.

33. Sexual violence against girls is a grave violation of human rights with severe health and social consequences. Approximately 150 million girls under the age of 18 are estimated to have experienced some form of sexual violence.[24] Together for Girls, a public-private partnership that involves five United Nations agencies, aims to eliminate sexual violence against children, with a focus on girls. It supports evidence-based prevention programmes and services for survivors of sexual violence in Kenya, Swaziland, the United Republic of Tanzania and Zimbabwe. Most recently, in the United Republic of Tanzania, a national survey on violence against children spurred Government commitment to develop a national action plan to reduce violence against children and support survivors.

IV. Sexual and reproductive health and reproductive rights

34. The Programme of Action of the International Conference on Population and Development and the key actions for its further implementation clearly state the right of adolescents to the highest attainable standards of health, including sexual and reproductive health. This includes providing appropriate, specific, user-friendly and accessible services to address their reproductive and sexual health needs effectively.

35. The Committee on the Rights of the Child and the Committee on the Elimination of Discrimination against Women have recognized adolescents' right to contraceptive information and services.[25] Barriers remain, however, and lead to increased risk of HIV and other sexually transmitted infections and high rates of unintended pregnancy and abortion.

36. The Convention on the Rights of the Child recognizes the evolving capacities of adolescents to make decisions in matters affecting their lives, but many States still require parental consent for adolescents to obtain access to contraceptive information and services, which can deter adolescents from seeking them. Even where parental consent is not required, stigma around adolescent sexuality may deter adolescents or may result in services being denied them. Cost can also be a significant obstacle for adolescents.

37. While the importance of a comprehensive and integrated package of adolescent sexual and reproductive health information and services is widely

[24] See www.togetherforgirls.org (accessed 27 January 2012).

[25] For full citations, see UNFPA and Center for Reproductive Rights, "The right to contraceptive information and services for women and adolescents", briefing paper, New York, 2010.

recognized, there is enormous variety in what countries are supporting. There are many examples of national or smaller-scale action by Governments and non-governmental organizations to encourage safer sexual and reproductive health behaviours and a positive community and policy environment. Some of those programmes work through the health system, and others work outside of it; the most effective ones are led by the health sector, with complementary actions in education, protection and employment. Historically, sexual and reproductive health programmes tend to be separate from HIV and AIDS prevention and treatment, and adolescent sexual and reproductive health services may be separate from other services for young people, although there is an encouraging trend towards integrated services.

38. There are good examples of programmes that deliver integrated health services, including sexual and reproductive health services, which are focused on young people's unique needs and expectations. They typically feature extended hours of service, confidentiality and privacy, personnel trained to work effectively with adolescents and reduced costs. An example is Geração Biz in Mozambique, which reaches more than 4 million young people in schools and community centres using 7,000 peer educators and health providers trained on youth-friendly services. The programme is managed in rotation by the Ministries of Education, Health and Youth, ensuring a cross-sectoral approach.

39. The National Adolescent-Friendly Clinic Initiative in South Africa aims to make health services more accessible and acceptable to young people, establish national standards and criteria for adolescent health care in accredited clinics throughout the country and develop the capacity of health-care workers to deliver quality services.[26] In Zambia, the Ministry of Health and its partners are building the capacity of community-based groups to provide integrated reproductive health information and services for young people, especially young rural girls.

40. In Mongolia, adolescent health centres provide reproductive health information, education and services while increasing adolescents' capacity to make decisions for their own well-being and health. Operated by district health alliances and provincial health departments, the service package integrates the prevention and management of reproductive tract and sexually transmitted infections. Access is encouraged by messages in the media and through sexuality education in schools.

41. In India, the Ministry of Health and Family Welfare, with its partners, is implementing a core adolescent sexual and reproductive health package for both married and unmarried adolescents at all levels of the national health system. One strategy is to set up special stalls during village fairs to reach both adolescents and the larger community of adults who interact with them.

42. Egypt has established an integrated national programme to educate adolescents about reproductive health and offer them guidance about services. Another component raises community awareness, breaking cultural and social barriers and encouraging adolescents to speak out about sensitive issues.

43. In the Plurinational State of Bolivia, the Mamás Jóvenes project held group peer-support sessions at health-care centres for pregnant adolescents and their

[26] Joanne Ashton, Kim Dickson and Melanie Pleaner, *Evolution of the National Adolescent-Friendly Clinic Initiative in South Africa* (Geneva, WHO, 2009). Available from http://whqlibdoc.who.int/publications/.

families. The centres provided a safe and private location for antenatal and post-natal check-ups and family planning.[27]

44. The Plan Andino de Prevención del Embarazo Adolescente is an initiative of the six Andean countries, combining the work of health and education ministries to prevent adolescent pregnancy. Colombia, for example, is building health workers' capacity to work with adolescents and promoting social mobilization and communications in support of young people's access. The Declaration on the prevention of adolescent pregnancy in the Andean subregion, adopted in Medellin, Colombia, in September 2011, places efforts to reduce adolescent pregnancy at the heart of the fight against intergenerational poverty.

45. In Georgia, UNFPA pioneered a model that engages the private sector to deliver services. Youth-friendly centres throughout the country provide services free of charge.

46. In the Russian Federation, the Ministry of Health and Social Development and UNICEF have developed an easily accessible range of age-appropriate health, social, psychological and information services. To date, 117 facilities have been established in 28 regions, serving approximately 1.5 million young people.[28] To ensure the scaling-up of services, a training centre was established for health and social service providers.

47. In the Republic of Moldova, part of the strategy to promote and safeguard the health of young people has been to establish youth-friendly health centres. The Ministry of Health is now scaling up youth-friendly services and integrating them into the national health system.

48. A strategy known as demand-side financing provides vouchers directly to girls who need services, overcoming household barriers.[23] In Nicaragua, girls were able to use vouchers for reproductive health care at the clinic of their choice. In Zambia, health workers made vouchers available for emergency contraception.[29]

49. Gaps in laws and regulations, poor application in practice and inadequate enforcement prevent many adolescents from reaching sexual and reproductive health information and services. The WHO tool for conducting rights-based national sexual and reproductive health law and policy assessments includes a module on barriers to adolescents' access. Sri Lanka and Tajikistan have carried out adolescent sexual and reproductive health assessments, to be followed by legislative reform.

50. A growing number of countries have established service quality standards. WHO has supported countries in defining, standardizing and improving the quality of health service provision to adolescents and in expanding the coverage of health services, for example in the United Republic of Tanzania, where the Ministry of Health and Social Welfare has made progress in standardizing and institutionalizing adolescent-friendly services at the national level. The current focus is on supporting

[27] Save the Children, "Adolescent reproductive and sexual health update", Department of Health and Nutrition Knowledge Series (Washington, D.C., 2011).

[28] Valentina Baltag and Alex Mathieson, eds., "Youth-friendly health policies and service in the European region: sharing experiences" (Copenhagen, WHO, 2010). Available from www.euro.who.int.

[29] John Skibiak, Mangala Chambeshi-Moyo and Yusuf Ahmed, "Testing alternative channels for providing emergency contraception to young women", July 2001. Available from www.popcouncil.org.

health management teams and facility managers at the regional, council and local levels.

51. Addressing girls' sexual and reproductive health calls for action outside the health system to change social norms, create community resources that empower girls and increase the health-related benefits of schooling and other investments. Communications media strongly influence young people's knowledge, attitudes and behaviours and can be a channel for sexuality education. In South Africa, the television drama series *Soul City* is credited with a shift in attitudes and norms about intimate partner violence and domestic relations.[30] Providing safe spaces permits girls to socialize with peers; learn how to protect their health and manage their money; and develop relationships with mentors and role models in their community. Using those tools, they can begin to exert some control and autonomy over their lives.[30] For example, the Biruh Tesfa programme in Ethiopia provides safe spaces for girls who have migrated to urban areas and are at risk of coerced sex and exploitative labour. More than 35,000 girls have participated in Biruh Tesfa groups in the poorest areas of 17 cities.[31]

52. In Nepal, a new project provides safe spaces for workshops, discussion forums and role-playing to engage girls and their parents. The programme works with community leaders, teachers and peers and supports local health facilities to provide adolescent-friendly services.[27]

V. HIV and young people

53. In 2001, Member States at the special session of the General Assembly on HIV/AIDS unanimously adopted the Declaration of Commitment on HIV/AIDS. That commitment was renewed five years later with the 2006 Political Declaration on HIV/AIDS (General Assembly resolution 60/262, annex). Member States agreed to further their commitment to addressing the rising rate of new HIV infections among young people and to implement comprehensive, evidence-informed prevention programmes that promote responsible sexual behaviour, including the use of condoms; evidence-informed and skills-based HIV education through mass media, schools and other settings; and the provision of youth-friendly sexual and reproductive health services, including HIV services.

54. The trajectory of the disease worldwide has been bending downward among young people: the *World AIDS Day Report 2011*[32] indicated a decline in HIV prevalence among young people in at least 21 of 24 countries with a national HIV prevalence of 1 per cent or higher. The declines in new infections in young people are being spurred by changes in sexual behaviour (waiting longer to become sexually active, choosing to have fewer partners and using condoms) and increased access to treatment.

---

[30] Ilene Speizer, Robert Magnani and Charlotte Colvin, "The effectiveness of adolescent reproductive health interventions in developing countries: a review of the evidence", *Journal of Adolescent Health*, vol. 33, No. 5 (November 2003).

[31] See www.popcouncil.org/projects/41_BiruhTesfaSafeSpaces.asp.

[32] UNAIDS, *World AIDS Day Report 2011: How to Get to Zero — Faster. Smarter. Better* (Geneva, 2011).

55. In the 2011 Political Declaration on HIV and AIDS (General Assembly resolution 65/277, annex), Member States recommitted to working towards reducing the sexual transmission of HIV by 50 per cent by 2015, including among young people. Three bold results have been agreed upon in order to achieve the overall goal, namely: comprehensive knowledge of HIV among at least 80 per cent of young people in and out of school; doubling of young people's use of condoms; and doubling of HIV testing and counselling services.

56. A recent report of national AIDS spending[33] found that three categories of spending focused on young people: in school, out of school, and orphans and other vulnerable children. Strategies for young people are included in national multisectoral strategies to respond to HIV in 151 of 172 countries. However, few countries provided detailed information on HIV among young people and the programmes that engage them. Of 90 plans reviewed by UNAIDS, 73 mentioned programmes and activities for young people, but only 34 provided specifics.

57. A study of HIV-positive young people receiving antiretroviral therapy in Kenya and Uganda found that most were sexually active, yet contraceptive use was low and there were high rates of unintended pregnancies. Even among young pregnant women receiving the therapy, the use of maternal health services, including for the prevention of mother-to-child transmission, was low.[34]

58. Many young people have limited or no access to HIV prevention programmes. Legal restrictions, the structure of services, community resistance and local customs present considerable barriers. In the most severely affected countries, very few young people have access to HIV testing and counselling services. All countries, with the exception of Namibia, report that less than 20 per cent of young people have been tested and counselled in the past year.

59. An estimated 10 billion male condoms are needed every year to cover all risky sex acts. Yet, in 2010, only nine male condoms were available for every adult male of reproductive age in sub-Saharan Africa. A female condom was distributed for every 50 women worldwide, or one for every 13 women of reproductive age in sub-Saharan Africa. Low- and middle-income countries rely heavily on the donor community, mainly UNFPA and the United States Agency for International Development, which provided 3.2 billion male condoms in 2007 to developing countries but only 2.8 billion in 2010.[35]

60. Prevention efforts in Zimbabwe have expanded since 2000, although they remain underfunded in comparison to other countries in the region. Extensive education among young people resulted in high levels of knowledge about HIV prevention, increased male and female condom use and a substantial decline in non-regular or casual sexual partners.[36]

---

[33] UNAIDS, *Securing the Future Today: Synthesis of Strategic Information on HIV and Young People* (Geneva, 2011).

[34] Harriet Birungi and others, "Sexual and reproductive health needs of adolescents perinatally infected with HIV in Uganda", July 2008. Available from www.popcouncil.org.

[35] See www.unfpa.org for information on comprehensive condom programming.

[36] Simon Gregson and others, "HIV decline in Zimbabwe due to declines in risky sex? Evidence from a comprehensive epidemiological review", *International Journal of Epidemiology*, vol. 39, 2010.

61. In Uganda, with a prevalence of 4.9 per cent for young people aged 15-24 years, the AIDS Commission has included young people in the national strategic plan on HIV/AIDS. The plan emphasizes HIV prevention among the vulnerable and most at risk. National policy is to integrate HIV services with reproductive health services.

62. In Indonesia, programmes have been successful in reaching out to most at-risk young people by partnering with non-governmental organizations and providing vital education and health services through tailor-made programmes based on the characteristics and needs of the targeted population.

63. In the Islamic Republic of Iran, the Government is partnering with UNICEF in a pilot project to empower young people to prevent HIV. It provides information, education, counselling and referral services in health centres and the community and will develop models for effective interventions. On the basis of experience and lessons learned, the programme will in future respond to the vulnerabilities of young women, strengthen the capacity of service providers and increase the use of services by at-risk children, youth and women. At the policy level, adolescent-friendly HIV prevention services will be integrated into the new national strategic plan.

VI. Comprehensive sexuality education

64. In line with the Programme of Action of the International Conference on Population and Development and the key actions for its further implementation, UNFPA, among other United Nations agencies, supports countries in providing age-appropriate information about sexuality and reproductive health in a manner consistent with young people's evolving capacities and parents' rights and responsibilities. Sexuality education includes structured opportunities for young people to explore their attitudes and values and to practice decision-making, communication and other life skills necessary for making informed choices about their sexual and reproductive lives. Extensive research shows that comprehensive sexuality education does not lead to increased risk behaviour among adolescents or promote early sexual activity.[37] To the extent that programmes provide adolescents with full and correct information, they explode myths, clear up misunderstandings, clarify values and reinforce positive attitudes.

65. The cooperation and support of parents, families and other community leaders and actors should be sought from the outset of the programmes. Ministries of Education play a critical role in building consensus on the need for sexuality education through consultation and advocacy with key stakeholders, including young people, parents, policymakers and politicians.

66. Research and international technical guidance supported by UNESCO, UNAIDS, UNFPA, UNICEF and WHO demonstrate the characteristics of effective programmes and confirm the importance of a comprehensive sexuality education that addresses gender and sexuality norms.[37] Unequal power in intimate relationships is associated with earlier sexual initiation, more sexual partners, more frequent unprotected sexual intercourse, lower rates of condom and contraceptive

[37] UNESCO, *International Technical Guidance on Sexuality Education: An Evidence-Informed Approach for Schools, Teachers and Health Educators* (Paris, 2009). Available from http://unesdoc.unesco.org/.

use, and higher incidence of HIV. Increasingly, education programmes address male behaviour, coercion and violence, but they should also take into account the root causes that reinforce such behaviour.

67. Despite increased support to comprehensive sexuality education at the secondary school level, sexuality education is generally unavailable to older school-age children, and out-of-school programmes are limited. In some pilot districts in Indonesia, sexuality education has been introduced at the junior high school level, either mainstreamed into existing subjects or as a stand-alone subject. The Ministry of Education and Culture, the Indonesia Planned Parenthood Association and UNFPA are working with teachers and young people to develop relevant guidance and tools for locally appropriate teaching. UNFPA is collaborating with the Ministry of Education and Culture to include sexuality education in the national education system.

68. Since 1998, the Government of Mongolia has provided sexuality education in schools from the third to the tenth grades. With support from UNFPA and technical assistance from the Margaret Sanger Center, national experts were trained to develop a sexuality education curriculum, which was rolled out across the country in 2004.

69. UNFPA partners with the Government and non-governmental organizations to support youth peer education at summer camps in Georgia. Since 2006, more than 39,500 young people have attended interactive sessions conducted by trained peer educators on sexual and reproductive health and reproductive rights, HIV prevention and gender and a healthy lifestyle.

70. In Togo, the Association togolaise pour le bien-être familial has promoted sexuality education in partnership with the Danish International Development Agency (DANIDA) and the Government, with radio and television programmes, round-table meetings, reflection days with religious leaders, youth workshops and meetings with district authorities. It also assembled a coalition of national non-governmental organizations and local associations, which produced a new national curriculum for preschools and primary schools and a self-learning manual and module for teachers.

71. Colombia piloted a comprehensive approach to sexuality education in 2005. With technical assistance from UNFPA, the Ministry of Education has scaled up the programme to the national level, engaging the health sector, universities and non-governmental organizations. In November 2010, the Ministry launched a new four-year plan that prioritizes education in sexuality and citizenship. Similarly, Argentina is implementing a nationwide initiative on sexuality education.

72. Promundo in Brazil has developed innovative campaigns and programmes to address gender stereotypes and early socialization and to promote healthier, more equitable relationships among young men and women. The programme has been adapted for other countries, including India and Mexico.

73. In Nigeria, the national family life and HIV and AIDS education curriculum has broadened access to sexuality education for young people. It is a result of a partnership between the Government and non-governmental organizations. An electronic version of the curriculum is now available as a resource for parents, teachers and young people.[23] Girls' Power Initiative, a partner non-governmental organization, also conducts outreach programmes for girls.

74. In Egypt, the main modality for sexuality education is peer education, both within and outside the school. UNFPA collaborates with the National Council for Childhood and Motherhood on a peer education programme in 14 districts to reach out-of-school youth. In addition, UNFPA has collaborated with a prestigious religious centre to produce a guide on reproductive health topics for religious leaders, addressing topics such as female genital mutilation and contraception.

VII. Humanitarian settings

75. The Programme of Action of the International Conference on Population and Development and the key actions for its further implementation recognize the situation of refugees and internally displaced people and highlight the need to ensure the effective protection of and assistance to refugee populations, with particular attention to the needs and physical security of refugee women and refugee children. Conflicts and disasters disrupt familial and social structures and have a dramatic impact on young people's safe and healthy development. Young people in humanitarian crisis situations are at risk of unwanted pregnancy, unsafe abortion and sexually transmitted infections, including HIV. Boys and girls are vulnerable to rape and sexual exploitation and abuse, a reality that the Security Council has recognized through several resolutions on sexual violence.

76. Empowering young people and promoting their leadership and participation in conflict and post-conflict settings requires political support and concerted efforts. With the support of UNFPA, countries have increasingly incorporated young people's sexual and reproductive health needs in their national emergency preparedness plans.

77. UNFPA and Save the Children issued the Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings,[38] which includes user-friendly tools for ensuring priority sexual and reproductive health interventions; assessing adolescent needs; fostering participation with communities and parents; and identifying adolescent sexual and reproductive health entry points in health programmes. It also contains tools for service providers to work more effectively with adolescents at the clinic and community level.[39]

78. With the Women's Refugee Commission, UNFPA supported an advocacy video entitled *Youth Zones: Voices from Emergencies*.[40] Screenings raised the attention of policymakers, donors and programme managers to the challenges and capabilities of young people in emergency settings.

79. UNFPA and UNDP[41] have been working closely with the United Nations and other partners to address HIV and gender-based violence among female combatants and young girls associated with armed forces and armed groups. Programmes are being implemented successfully in the Comoros, Côte d'Ivoire, Indonesia, Nepal and the Sudan.

---

[38] See www.unfpa.org/public/global/publications/.

[39] See www.rhrc.org/resources/arh/player.html.

[40] See www.youthzones.org.

[41] UNFPA and UNDP are co-chairs of the sub-working group on gender, HIV and disarmament, demobilization and reintegration of the Inter-Agency Working Group on Disarmament, Demobilization and Reintegration.

80. In Haiti, after the 2010 earthquake, young people conducted post-disaster rapid needs analyses, including camp assessments to find pregnant women and provide them with extra food. Young people also ensured condom availability and conducted HIV/AIDS awareness sessions.

81. In response to the recent events in Egypt, UNFPA convened an inter-agency task force to coordinate activities and initiatives that focus on young people. The task force provides volunteer opportunities for young people to share information, coordinate activities and engage in policy and programmatic decision-making.

VIII. Major partnerships and networks

82. Young people have a right to participate in programmes that affect them, and with training and assistance they can become powerful advocates for positive change. Opportunities for youth participation are important both for the development of individuals and for the social, political and economic stability of the larger society. Young people's experience of citizenship and community involvement affects the extent and kind of civic participation throughout their lives.

83. Governments and the United Nations are working in partnership with youth-led organizations to promote youth engagement and participation. The Youth Peer Education Electronic Resource programme is one example of youth participation in programming. Its networks promote sexual and reproductive health and provide peer counselling and information across the Arab States and Eastern Europe. It aims to build the capacity of young people to be activists and educators in their communities, involving them directly in programming to increase young people's knowledge of sexual and reproductive health issues. In the occupied Palestinian territories, the programme, supported by the Ministry of Social Affairs, is being expanded to disadvantaged youth groups. More than 300 peer educators have been trained, including about 100 in Gaza. The approach is being expanded and adopted by other youth non-governmental organizations.

84. In Nepal, UNFPA and Restless Development co-chair the inter-agency working group on youth and closely collaborate with the Government on youth policy. United Nations working groups work closely with youth-led organizations at the regional level in Latin America and in the Arab States. At the global level, the UNAIDS Inter-Agency Task Team on HIV and Young People, co-chaired by UNFPA and UNICEF, includes youth-led organizations as members, an example of good practice in youth-adult partnership. The United Nations Inter-Agency Network on Youth Development includes more than 30 entities within the United Nations and cooperates closely with youth organizations. The United Nations Inter-Agency Task Force on Adolescent Girls calls for greater investments in girls' rights, education, health and development as part of an essential strategy for breaking the intergenerational cycle of poverty.

85. At all levels, youth organizations are working in partnership to develop joint priorities and actions. In Afghanistan, Youth in Action Association provides a platform for youth organizations across the country to develop common advocacy messages and strategies. During the International Year of Youth, a coalition of youth organizations, in partnership with UNFPA, developed an advocacy and communications strategy that produced blogs by youth journalists on youth participation in decision-making processes, art contests on HIV prevention,

workshops and training activities, including a campaign on the theme "10 days of activism".

86. The Coalition for Adolescent Girls brings together more than 30 international organizations. In 2011, the Clinton Global Initiative continued to encourage discussion on investments and solutions in this area, and The Elders launched Girls Not Brides, a global partnership of non-governmental organizations to end child marriage, support child brides and raise the profile of this neglected problem.

87. Many global partnerships and networks promote young people's rights and access to sexual and reproductive health services. The International Planned Parenthood Federation has catalysed a global youth movement for sexual and reproductive health and strengthened the capacity of its 170 member associations to deliver services. The Inter-Agency Youth Working Group coordinated by Family Health International is a network of organizations with an interest in improving the sexual and reproductive health of young people in developing countries. UNFPA has also mobilized youth-led networks and youth-adult partnerships to promote the agenda of the International Conference on Population and Development for young people at the national, regional and international levels.

IX. Challenges and the way forward

88. Countries have made progress towards the commitments made in the Programme of Action of the International Conference on Population and Development, the key actions for its further implementation and the Millennium Development Goals. However, despite the compelling evidence of the importance of young people to countries' prospects for development, investments in young people continue to lag behind.[22] Urgent efforts are needed to protect, promote and fulfil the human rights of young people, especially the right to sexual and reproductive health.

89. Policy frameworks should be multisectoral, bringing together relevant ministries, national institutions, donors and stakeholders to initiate an integrated approach to young people's issues, including health, education, employment, social integration and strategies for sustainable livelihoods (see General Assembly resolutions 50/81, annex, paras. 113 and 114; and 65/312, para. 9).

90. Adolescent sexual and reproductive health should be included as a development priority, as well as a human right, with appropriate budgets. Legal, rights and policy frameworks for adolescent sexual and reproductive health remain weak and services inadequate. There continue to be systemic challenges to women's empowerment, gender equality and young people's access to sexual and reproductive health, including social attitudes and practices.

91. There are many barriers that hinder access to an integrated package of sexual and reproductive health and HIV services, especially for vulnerable groups. Among those are legal and policy issues, stigma and discrimination and social and cultural factors. It is vital to extend coverage of key interventions, including changing social norms and laws. Opportunities exist to reshape the legal and social milieu that compounds vulnerability and marginalization, leading to HIV infection.

92. Organizational difficulties include physically inaccessible services, which are not youth-friendly and do not meet the standards of quality, privacy, confidentiality and informed consent. Some countries hoping to move away from stand-alone

adolescent sexual and reproductive health services are experiencing difficulty in scaling up integrated initiatives. Many services are not youth friendly. Despite the provision of training, many health providers remain judgemental and lack the skills to work with adolescents in a sensitive and confidential way. Services are commonly oriented to adult women with children and do not reach out to the youngest, including first-time mothers and married adolescents without children. Laws and policies may restrict services available to unmarried adolescents.

93. Health policies, health service delivery systems and financing should ensure access to comprehensive, age-appropriate sexual and reproductive health information and services for both married and unmarried young people. These should include contraceptive information and services, including male and female condoms for the prevention of pregnancies and HIV infections; care in pregnancy and childbirth; safe abortion services, in circumstances where abortion is not against the law; access, in all cases, to quality services for the management of complications arising from abortion; post-abortion counselling, education and family planning; voluntary HIV counselling and testing and antiretroviral treatment; prevention and treatment of sexually transmitted infections; information and counselling on sexual and reproductive health; and gender-based violence screening and services.

94. All services should reach the most marginalized, disabled persons and hard-to-reach youth populations, particularly girls. Improved coordination and referral between health and education systems is needed to provide more integrated support for young people.

95. Girls and young women, both married and unmarried, need protection from all forms of gender-based violence, abuse and exploitation, including unwanted and coerced sex. Programmes that build the capacity of young people to protect themselves are needed. Those who experience violence should have prompt access to protection, the requisite services and justice. Child marriage remains a serious health, social and human rights problem, especially in poor and rural communities.

96. Out-of-school girls, in particular, need safe spaces to strengthen their health knowledge and life skills and expand their social networks. Safe spaces should create catch-up schooling opportunities and provide access to services. Programmes should also respond to the needs of boys and young men so as to promote the concepts of gender equality and mutual respect and offer appropriate role models.

97. Policies should promote gender-sensitive, age-appropriate, life-skills-based comprehensive sexuality education for young people both in and out of school, based on international standards. Curricula should have regard to the evolving capacities of young people at different ages to make their own decisions. Special attention should be paid to the needs of the most marginalized and most at-risk adolescents, including refugee and displaced populations. Young people living with HIV should be engaged to ensure that policies and programmes address their sexual and reproductive health needs and concerns and eliminate stigma and discrimination against them.

98. Countries should ensure the participation of young people, in particular the most marginalized among them, in the drafting and execution of policies, promoting their human rights and their role as agents of social progress and peacebuilding. They should mainstream young people's needs and perspectives in all post-conflict, peacebuilding, post-disaster and recovery processes and sectors.

99. New technologies should be harnessed in order to improve access to education, promote youth involvement in governance and ensure that investments reach marginalized young people, especially adolescent girls. Special efforts are needed on behalf of young people who are internally displaced or refugees or live in difficult humanitarian situations.

100. Investment in data, knowledge generation and capacity development concerning young people is an essential element. Policy strategies should encourage research and systematic generation of data on young people, most particularly the youngest (10 to 14-year-old) girls. They should ensure that data collection and analysis reflect the priorities of adolescents and youth, are disaggregated by age and sex and are used to enrich the understanding of youth issues, inform policy discussions and interventions and strengthen the evidence base on the importance of investing in young people.

United Nations E/CN.9/2012/6

Economic and Social Council

Distr.: General
3 February 2012

Original: English

Commission on Population and Development
Forty-fifth session
23-27 April 2012
Item 3 of the provisional agenda*
Actions in follow-up to the recommendations of the International Conference on Population and Development

Flow of financial resources for assisting in the implementation of the Programme of Action of the International Conference on Population and Development

Report of the Secretary-General

Summary

The present report responds to a request made by the Commission on Population and Development at its twenty-eighth session, in its proposed agenda, for an annual report on the flow of financial resources for assisting in the implementation of the Programme of Action of the International Conference on Population and Development. The report also complies with General Assembly resolutions 49/128 and 50/124, in which the Assembly called for the preparation of periodic reports on the flow of financial resources for assisting in the implementation of the Programme of Action.

The report examines levels of donor and domestic expenditures for population activities in developing countries for 2010 and provides estimates for population expenditures in 2011 and projections for 2012. Donor assistance, which has been increasing steadily over the past few years, is showing definite signs of slowing down: it stood at $10.6 billion in 2009 and increased slightly to $10.7 billion in 2010. Donor assistance is projected to increase somewhat, to $11.4 billion in 2011 and to $11.9 billion in 2012.

A rough estimate of resources mobilized by developing countries as a group yielded a figure of $33.7 billion for 2010. The 2011 and 2012 figures are expected to follow the same pattern, increasing to $35 billion in 2011 and to $38 billion in 2012.

* E/CN.9/2012/2.

12-22346 (E) 270212

Please recycle

While the Programme of Action established that one third of funding would be borne by external sources and two thirds by developing countries, the actual situation reveals that developing countries are funding just over three fourths of population expenditures and that private consumers in those countries are spending over half of domestic resources through out-of-pocket expenditures. This has important implications with regard to access, reaching the most marginalized and the pace of progress in achieving key indicators.

Despite modest increases, current funding levels are below the amounts necessary to fully implement the Programme of Action and achieve the Millennium Development Goals. This is true for all four components of the population package costed under the International Conference on Population and Development: family planning; basic reproductive health; sexually transmitted diseases/HIV/AIDS prevention activities; and basic research, data and population and development policy analysis. Given the current financial scenario, it is not likely that this situation will improve in the near future.

Contents

		Page
I.	Introduction	4
II.	International assistance to population activities	5
	A. Bilateral assistance to population activities	6
	B. Multilateral assistance to population activities	7
	C. Private assistance to population activities	8
III.	Expenditures for population activities	8
	A. Expenditures for population activities by geographic region	9
	B. Expenditures for population activities by category of activity	9
	C. Expenditures for population activities by channel of distribution	11
IV.	Domestic expenditures for population activities	11
	A. Methodology	11
	B. Estimates and projections of domestic expenditures	12
	C. Components of domestic funding for population activities	13
V.	Funding requirements to achieve the objectives of the International Conference on Population and Development	14
VI.	Major challenges in implementing the financial targets of the International Conference on Population and Development	18
VII.	Conclusion	18
	A. Progress in resource mobilization	18
	B. The way forward	19

I. Introduction

1. The present report has been prepared by the United Nations Population Fund (UNFPA) in response to a request by the Commission on Population and Development at its twenty-eighth session,[1] for an annual report on the flow of financial resources for assisting in the implementation of the Programme of Action adopted at the International Conference on Population and Development in Cairo in 1994.[2] The report is part of the programme of work of the Commission and is submitted in accordance with General Assembly resolutions 49/128 and 50/124, in which the Assembly called for the preparation of periodic reports on the flow of financial resources for assisting in the implementation of the Programme of Action.

2. The report reviews the flow of funds from donor countries for population assistance in developing countries[3] and provides estimates of governmental and non-governmental expenditures for population activities in developing countries for 2010. It also includes donor and developing country estimates for 2011 and projections for 2012. Data collection activities for both donor and domestic resource flows were undertaken by the Netherlands Interdisciplinary Demographic Institute under a contract with UNFPA. To build regional capacity to monitor resource flows, UNFPA and the Demographic Institute also work with the Indian Institute of Health Management Research in the collection of data on domestic expenditures and, since 2011, with the African Population and Health Research Center. Evaluation and analysis of data have been carried out jointly by UNFPA and the Demographic Institute.

Methodology

3. A detailed questionnaire was mailed to 125 key actors in the field of population and AIDS research, including major multilateral organizations and agencies, large private foundations and other non-governmental organizations (NGOs) that provide substantial amounts of population assistance, and the donor countries to the Development Assistance Committee of the Organization of Economic Cooperation and Development (OECD). To decrease respondent fatigue, coordinate monitoring of resource flows and ensure consistency in reporting, as much information from donor countries as possible has been obtained from the database of the Development Assistance Committee. In the absence of complete data from major donors by the publication deadline, information contained in the report is also based on estimates, taking into account past funding behaviour.

4. Information on domestic resource flows is based on data supplied by Governments and non-governmental organizations in developing countries throughout the world, secondary sources and estimations and projections.

5. The external and domestic financial resource flows for population activities analysed in the report are based on the "costed population package", as specified in paragraph 13.14 of the Programme of Action. The package comprises family

[1] See *Official Records of the Economic and Social Council, 1995, Supplement No. 7* (E/1995/27), annex I, sect. III.

[2] *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994* (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex.

[3] All references to developing countries in the present report include countries with economies in transition.

planning services; basic reproductive health services; sexually transmitted diseases/HIV/AIDS prevention activities;[4] and basic research, data and population and development policy analysis.

II. International assistance to population activities

6. Donor assistance to population activities continues to increase, although at a slower rate than in the past. After surpassing $10 billion in 2008, assistance increased slowly in 2009 and 2010. Donor assistance stood at $10.6 billion in 2009. The provisional figure for 2010 is $10.7 billion (see table 1). Funding was expected to increase to $11.4 billion in 2011 and to reach $11.9 billion in 2012. With a number of donors still in the grips of the global financial crisis, it is likely that the final figures for 2011 and 2012 will be below the estimates set out in table 1.

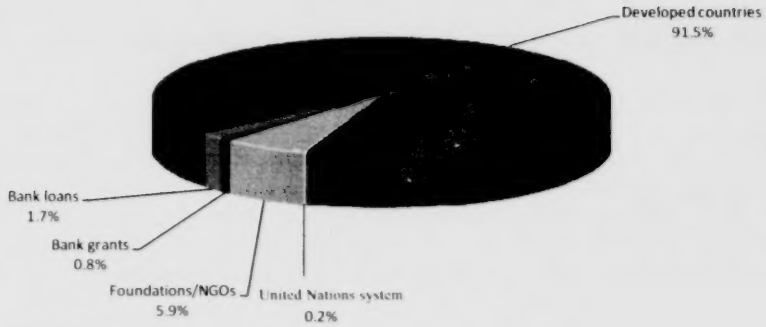
Table 1
International population assistance by major donor category: 2009-2012
(Millions of United States dollars)

Donor category	*2009*	*2010 (Provisional)*	*2011 (Estimated)*	*2012 (Projected)*
Bilateral assistance				
Developed countries	9 579	9 801	10 417	10 834
Multilateral assistance				
United Nations system	36	20	40	42
Grants from development banks	95	86	106	110
Loans from development banks	295	177	177[a]	177[a]
Private assistance				
Foundations/NGOs	622	632	693	718
Subtotal without bank loans	**10 332**	**10 539**	**11 256**	**11 704**
Total	**10 628**	**10 716**	**11 433**	**11 881**

[a] The 2011-2012 figures for development bank loans are estimated at the 2010 level.
Source: UNFPA, 2011, *Financial Resource Flows for Population Activities in 2009* and Resource Flows Project database.
Note: Totals may not add up due to rounding.

[4] Beginning with the 1999 round of questionnaires, the UNFPA/Netherlands Interdisciplinary Demographic Institute Resource Flows Project has included data on HIV/AIDS treatment and care in order to address the growing reporting needs of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and because it was increasingly becoming impossible for respondents to provide information on HIV/AIDS prevention activities alone. Since 2008, in order to ensure one AIDS figure, all data on HIV/AIDS expenditures have been obtained directly from UNAIDS using the broader definition of AIDS.

Figure I
Population assistance by source: 2010



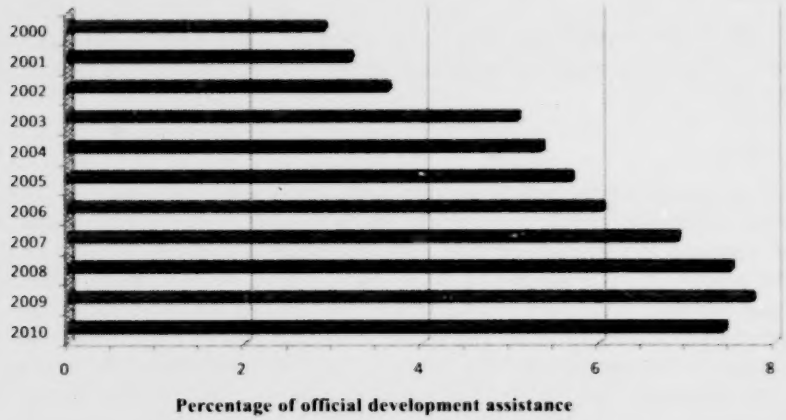
Source: Resource flows project database (figures are provisional).
Note: Totals may not add up due to rounding.

A. Bilateral assistance to population activities

7. Donor countries traditionally provide the largest share of population assistance. In 2010, bilateral assistance was estimated at $9.8 billion, an increase from just under $9.6 billion in 2009. Despite the financial difficulties faced by a number of donor countries, total population assistance continued to increase, although not at the same levels seen earlier. It is estimated that once all data are in population assistance from donor countries could reach $10.4 billion in 2011. Projections for 2012 place this figure at $10.8 billion, assuming a continuing upward trend.

8. According to the latest OECD figures, official development assistance (ODA) increased to $128.5 billion in 2010 from $119.7 billion in 2009. The percentage of total ODA that donor countries, as a group, contributed to population assistance decreased to 7.46 per cent in 2010 from 7.78 per cent in 2009 (see figure II). There are significant variations from 0.62 per cent to 16.93 per cent, between countries in the percentage of ODA spent on population activities.

Figure II
Population assistance of donor countries as a percentage of official development assistance: 2000-2010



Source: UNFPA, 2011, *Financial Resource Flows for Population Activities in 2009*, and Resource Flows Project database.
Note: Data for 2010 are provisional.

B. Multilateral assistance to population activities

9. Multilateral assistance to population activities consists of contributions provided by the organizations and agencies of the United Nations system and grants and loans provided by development banks.

United Nations system

10. Multilateral assistance originating from within the United Nations system mainly consists of funds from UNAIDS, UNFPA and the World Health Organization (WHO). Whatever funding United Nations agencies receive for population assistance from donor countries to the Development Assistance Committee is considered to be bilateral assistance. General funds of United Nations agencies not earmarked for population activities, interest earned on funds and money from income-generating activities that are spent on population activities are considered as multilateral assistance. Funds received from developing countries that agencies spend on population activities are a small portion of an agency's budget and are also included as multilateral assistance. Provisional figures for multilateral assistance originating with the United Nations system show a continued decrease, from $36 million in 2009 to $20 million in 2010. This could partially be a result of the economic slowdown and partly due to the fact that a number of United Nations agencies did not provide information by the deadline for the publication of the present report.

11. UNFPA is the leading provider of United Nations assistance in the population field, providing support to 123 developing countries in 2010. UNFPA relies on voluntary contributions and follows its strategic plan 2008-2013, the goal of which is to accelerate progress towards realizing the Programme of Action and the Millennium Development Goals, focusing on three key areas: population and

development; reproductive health and rights; and gender equality. The plan is results-based and specifies anticipated outcomes and indicators to measure results.

Bank grants

12. In 2010, the World Bank, the only development bank reporting expenditures for special grants programmes in population, decreased the total amount of its grants to $86 million.

Bank loans

13. Development banks, which provide loans to developing countries, are an important source of multilateral population assistance. Their contributions are treated separately from grants because such assistance is in the form of loans that must be repaid. Projects funded by bank loans reflect multi-year commitments, which are recorded in the year in which they are approved but are in fact disbursed over several years. Most loans for population assistance come from the World Bank, which supports reproductive health and family planning service delivery, population policy development, HIV/AIDS prevention and fertility and health survey and census work. In 2010, the World Bank provided $177 million in loans for population activities.

C. Private assistance to population activities

14. Foundations, NGOs and other private organizations are also important sources of population assistance. In 2010, it is estimated that foundations and NGOs contributed $632 million to population activities, up from $622 million in 2009. While they have been projected to increase such contributions again in both 2011 and 2012, the size of the increase will depend on how the foundations and NGOs have weathered the global financial crisis.

III. Expenditures for population activities

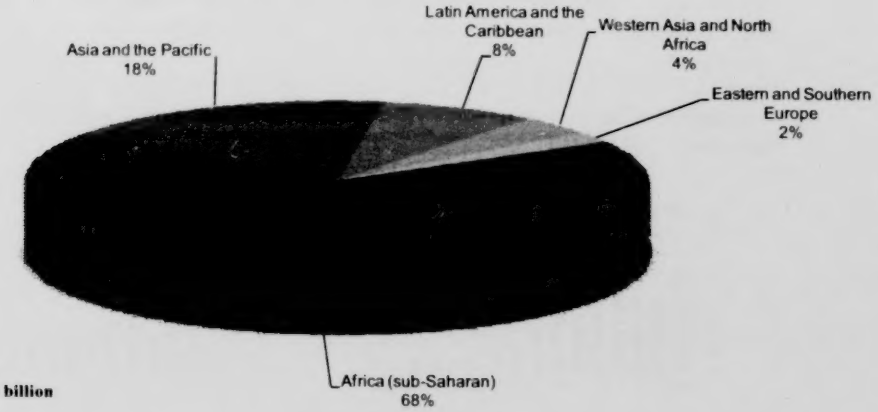
15. Figures for international population assistance reflect financial resources contributed by donors in a given year, while figures for expenditures reflect funds that have been received by developing countries in a given year. International assistance may be provided by a donor either directly to the developing country or to an intermediate donor such as a multilateral organization or international NGO. Recipients may be the Governments of developing countries, national NGOs or the field offices operated by donors in developing countries. International population assistance for a given year does not automatically equal the expenditures in that year since funds are not always spent in the same year in which they are received. This is oftentimes the case when funds are channelled through an intermediate donor. Thus, for example, funds provided by a donor to a recipient developing country in year A are included in international population assistance in year A and expenditures in year A. Funds provided by a donor to an intermediate donor in year A but spent by that intermediate donor in a recipient developing country in year B would be included under population assistance in year A and under expenditures in year B. Development bank loans are not included in expenditure figures because they reflect

large blocks of loan agreements made in a single year but intended to be spent over several years.

A. Expenditures for population activities by geographic region

16. Sub-Saharan Africa, which includes the majority of the least developed countries, continues to be the largest recipient of assistance, receiving 68 per cent of all assistance going to the five geographic regions (figure III). About 31 per cent of all population assistance goes to fund global and interregional population activities, including advocacy; research; reproductive health; HIV/AIDS prevention, care and support; and safe motherhood.

Figure III
Population assistance by geographic region: 2010



Source: Resource Flows Project database (figures are provisional).

B. Expenditures for population activities by category of activity

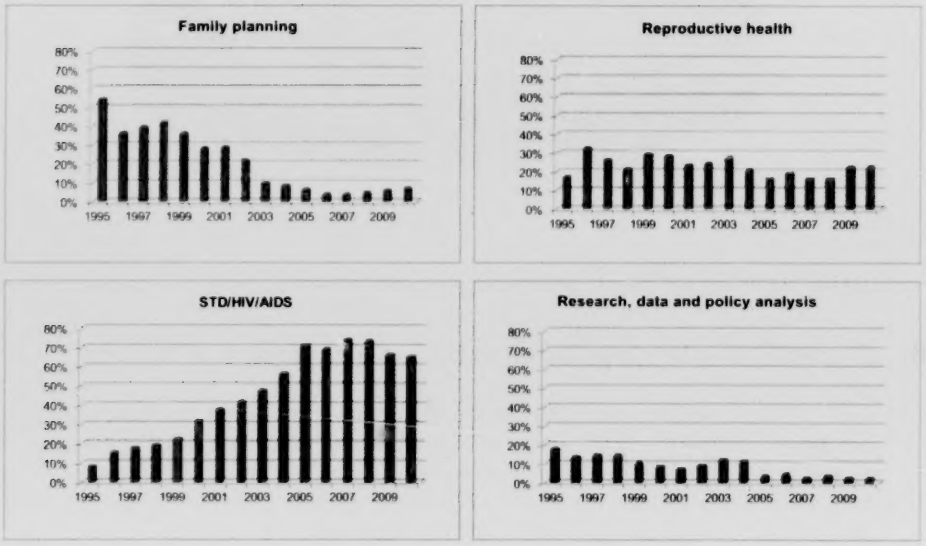
17. UNFPA monitors expenditures for population activities by the following four population categories costed under the International Conference on Population and Development: (a) family planning services; (b) basic reproductive health services; (c) sexually transmitted diseases/HIV/AIDS prevention activities; and (d) basic research, data and population and development policy analysis.

18. The growing trend towards the integration of services and the use of sector-wide approaches in development assistance is making it increasingly difficult for countries to readily distinguish between expenditures for population and other health-related activities and, within population activities, between family planning, reproductive health and sexually transmitted diseases/HIV/AIDS prevention activities. However, while precise figures may not always be available, it is still possible to estimate the amount of resources that are spent on each of the four categories of the costed population package. Monitoring expenditures for the separate categories is an important component of budgeting, policymaking and programme planning.

19. When all final figures are in, 2010 data are expected to show increases in funding for all four areas of the costed population package. This is most welcome. Funding for family planning services has lately been increasing in absolute dollar amounts and has actually surpassed the 1995 level, the year when UNFPA first began monitoring resource flows for the four costed population categories. Although funding for reproductive health and basic research activities also increased, HIV/AIDS activities continue to receive by far the most population assistance. While it is important to ensure a substantial amount of money to stop the spread of HIV/AIDS, it is also critically important to mobilize adequate resources for family planning and reproductive health, which are essential for achieving Millennium Development Goal 5, on improving maternal health, progress on which has been slower than that on the other Goals. Funding for reproductive health increased noticeably in both 2008 and 2009, and continued to increase in 2010. Funding for HIV/AIDS decreased for the first time in 2009 but provisional figures for 2010 point to an increase. Figure IV provides expenditures for population activities as a percentage of total population assistance for the four components of the costed population package from 1995 to 2010.

Figure IV

Expenditures for population activities as a percentage of total population assistance: 1995-2010



Source: UNFPA, 2011, *Financial Resource Flows for Population Activities in 2009*, and Resource Flows Project database.

C. Expenditures for population activities by channel of distribution

20. Assistance for population activities flows through a diverse network, moving from the donor to the recipient developing country through one of the following channels: (a) bilateral — directly from the donor to the recipient developing country Government; (b) multilateral — through United Nations organizations and agencies; and (c) non-governmental. The NGO channel is the predominant channel for funding. In 2010, it is estimated that about 41 per cent of population assistance was channelled through NGOs, compared to 32 per cent, which was received through bilateral channels, and 28 per cent, which came from multilateral sources. This trend is expected to continue in 2011 and 2012.

IV. Domestic expenditures for population activities

A. Methodology

21. The Programme of Action of the International Conference on Population and Development pointed out that the domestic resources of developing countries provide the largest portion of funds for attaining population and development objectives. The Programme estimated that two thirds of the funding required to finance population programmes would come from domestic resources. The mobilization of adequate domestic financial resources is therefore essential to facilitate full implementation of the agenda adopted in Cairo in 1994. UNFPA has been monitoring domestic expenditures for population activities since 1997. This has been done primarily through the use of survey questionnaires sent to UNFPA country offices throughout the world for further distribution to Government ministries and large national NGOs. Although most Governments make every effort to provide the requested information, many are often unable to supply data because of funding, staffing and time constraints. In addition, countries that do not have well-developed systems for monitoring resource flows are unable to provide information, especially when funding is pooled in integrated social and health projects and sector-wide approaches. Furthermore, most countries with decentralized Governments do not have accounting systems that can easily provide information on expenditures for population at subnational levels.

22. Total global domestic expenditures for population activities presented herein are estimated using a methodology that incorporates the responses of the surveyed countries, together with prior reporting on actual and intended expenditures and secondary sources on national spending. In the absence of such information, estimates and projections have been based on national income as measured by the level of gross domestic product (GDP), which has proved the most influential variable explaining the growth of spending by Governments.[5]

[5] See Erik Beekink, "Financial resource flows for population and AIDS activities, 2010-2012", UNFPA/UNAIDS/Netherlands Interdisciplinary Demographic Institute Resource Flows Project, The Hague, 2011.

B. Estimates and projections of domestic expenditures

23. The latest estimates and projections of global domestic expenditures for population activities for 2010-2012 are presented in table 2. The overall levels mobilized increased in 2010 and are projected to increase in 2011 and 2012. In large part this is a result of the fact that the figures are heavily influenced by a number of large booming economies that have remained generally unaffected by the global financial crisis. It is estimated that developing countries spent $33.7 billion for population activities in 2010. The largest amount was mobilized in Asia ($18.2 billion), followed by Latin America and the Caribbean ($7.5 billion), sub-Saharan Africa ($4.6 billion), Western Asia and North Africa ($2.1 billion) and Eastern and Southern Europe ($1.4 billion).

24. Domestic expenditures are estimated to have increased to $35 billion in 2011 and are projected to increase to $38 billion in 2012. Asia is expected to have mobilized the largest amount of financial resources in 2011 and to continue to do so in 2012. Latin America and the Caribbean is expected to mobilize the second largest amount of funds, followed by sub-Saharan Africa, Western Asia and North Africa and Eastern and Southern Europe.

25. It is estimated that 30 per cent of all domestic expenditures for population were spent on sexually transmitted diseases/HIV/AIDS prevention activities in 2010. This percentage varied considerably by region, from 91 per cent in Eastern and Southern Europe to 10 per cent in Western Asia and North Africa.

26. Because they are often incomplete and not entirely comparable, data on domestic resource flows are rough estimates. Such information is useful, however, in that it provides some idea of the progress being made by developing countries in achieving the financial resource targets of the Programme of Action. While the figures show a real commitment on the part of developing countries, they conceal the great variation that exists among countries in their ability to mobilize resources for population activities. Most domestic resource flows originate in a few large countries. Many countries, especially those in sub-Saharan Africa and the least developed countries, which are not able to generate sufficient resources to finance their own population programmes, rely heavily on donor assistance.

Table 2
Projection of Global Domestic Expenditures for Population Activities: 2010-2012
(Thousands of United States dollars)

	Source of funds				
Year	*Government*	*NGOs*	*Consumers*[a]	*Total*	*Percentage spent on sexually transmitted diseases/HIV/AIDS*
2010					
Africa (sub-Saharan)	2 121 709	116 735	2 321 438	4 559 382	90
Asia and the Pacific	5 160 254	177 904	12 818 072	18 156 230	12
Latin America and the Caribbean	4 266 645	77 195	3 171 390	7 515 231	30
Western Asia and North Africa	1 231 053	59 133	794 029	2 084 215	10
Eastern and Southern Europe	882 653	15 062	454 566	1 352 281	91
Total	**13 662 314**	**445 529**	**19 559 496**	**33 667 339**	**30**
2011					
Africa (sub-Saharan)	2 131 703	122 915	2 331 765	4 586 382	90
Asia and the Pacific	5 581 943	184 860	13 865 545	19 632 347	12
Latin America and the Caribbean	4 260 002	81 162	3 176 545	7 517 709	29
Western Asia and North Africa	1 272 772	60 975	820 938	2 154 684	10
Eastern and Southern Europe	889 065	15 952	457 868	1 362 885	90
Total	**14 135 484**	**465 863**	**20 652 662**	**35 254 008**	**29**
2012					
Africa (sub-Saharan)	2 138 024	127 326	2 338 297	4 603 647	90
Asia and the Pacific	6 459 091	189 930	16 044 383	22 693 404	10
Latin America and the Caribbean	4 279 324	83 825	3 191 097	7 554 247	29
Western Asia and North Africa	1 299 569	63 025	838 222	2 200 816	10
Eastern and Southern Europe	904 677	16 580	465 909	1 387 166	89
Total	**15 080 686**	**480 686**	**22 877 908**	**38 439 280**	**26**

[a] Consumer spending on population activities covers only out-of-pocket expenditures and is based on the average amount per region as measured by WHO for health-care spending in general. For each region, the ratio of private out-of-pocket versus per capita government expenditures was used to derive consumer expenditures in the case of population activities.

Source: Resource Flows Project database. See also Erik Beekink, "Financial resource flows for population and AIDS activities, 2010-2012", UNFPA/UNAIDS/Netherlands Interdisciplinary Demographic Institute Resource Flows Project, The Hague, 2011.

C. Components of domestic funding for population activities

27. Domestic funding for population activities comes primarily from Governments, national NGOs and private consumers. Governments are considered to be responsible for most domestic expenditures for population activities. However, since the level of Government funding usually depends on the level of national income, Governments in least developed countries, faced with many competing development priorities, often cannot afford to make the necessary investments in

population. They rely heavily on external funding from donors. National NGOs also contribute financial resources for population, but the majority of them are also highly dependent on international resources. Their main role lies in advocacy work and in reaching people at the grass-roots level.

28. Consumer spending as measured by out-of-pocket expenditures represents the largest part of resources spent on population activities. Private consumer expenditures account for a large percentage of total funding for health care. Although exact amounts of worldwide health-care spending for population activities are not known, it stands to reason that a significant proportion of expenditures for family planning, reproductive health and sexually transmitted diseases/HIV/AIDS services are borne by consumers. The few available sources of information on private spending reveal great variations between regions and countries and, in some cases, changes over time in the share of private spending within countries themselves. In estimating consumer spending, the Resource Flows Project used out-of-pocket health expenditures of households from the national health accounts figures as collected by WHO. The out-of-pocket health expenditures were assumed to be completely in line with out-of-pocket expenditures for population goods and services.

29. UNFPA and the Netherlands Interdisciplinary Demographic Institute are working on a strategy for the tracking of out-of-pocket expenditures for sexual and reproductive health that will provide a better understanding of this important component of domestic funding. At an expert meeting on out-of-pocket expenditures held in December 2011 current methods of tracking out-of-pocket expenditures, sharing experiences and exploring the possibilities for collecting data on such expenditures for sexual and reproductive health were discussed.

V. Funding requirements to achieve the objectives of the International Conference on Population and Development

30. To ensure adequate funding for the implementation of the Programme of Action, UNFPA reviewed the original estimates for the four categories of the costed population package and produced revised estimates to meet current needs and costs. These revised estimates, which were presented to the forty-second session of the Commission on Population and Development in 2009, are much higher than the original targets agreed upon at the International Conference on Population and Development in 1994 because they take into account both current needs and current costs and include interventions such as AIDS treatment and care and reproductive cancer screening and treatment, which were not part of the original costed population package.

31. Table 3 provides levels of funding required to achieve the objectives of the International Conference on Population and Development. In order to fully fund the necessary sexual and reproductive health, including family planning and HIV/AIDS services, as well as censuses, surveys, civil registration and population research and training, the international community would have needed to mobilize almost $65 billion in 2010. The costs are minimum estimates required to implement the goals set at the Conference in those areas. There will always be unspecified costs that fall outside the scope of the cost estimates as well as adjustments for demand generation, stock maintenance and similar expenses.

Table 3
Updated cost estimates for the implementation of the Programme of Action, by subregion: 2009-2015
(Millions of United States dollars)

	2009	*2010*	*2011*	*2012*	*2013*	*2014*	*2015*
Global	**48 980**	**64 724**	**67 762**	**68 196**	**68 629**	**69 593**	**69 810**
Sexual/reproductive health/family planning	23 454	27 437	30 712	32 006	32 714	33 284	33 030
Family planning, direct costs	2 342	2 615	2 906	3 209	3 529	3 866	4 097
Maternal health, direct costs	6 114	7 868	9 488	11 376	13 462	15 746	18 002
Programmes and systems related costs	14 999	16 954	18 319	17 422	15 723	13 672	10 931
HIV/AIDS	23 975	32 450	33 107	33 951	34 734	35 444	36 189
Basic research/data/policy analysis	1 551	4 837	3 943	2 239	1 181	864	591
Sub-Saharan Africa	**20 063**	**27 075**	**29 473**	**29 869**	**30 292**	**30 022**	**28 980**
Sexual/reproductive health/family planning	8 482	10 612	12 596	12 675	12 764	12 184	10 731
Family planning, direct costs	329	414	506	606	713	827	931
Maternal health, direct costs	1 429	1 833	2 280	2 771	3 306	3 883	4 411
Programmes and systems related costs	6 725	8 366	9 809	9 298	8 746	7 473	5 389
HIV/AIDS	11 228	15 891	16 227	16 746	17 243	17 638	18 110
Basic research/data/policy analysis	353	571	651	449	285	200	139
Asia and the Pacific	**17 549**	**23 281**	**23 923**	**23 788**	**23 862**	**24 415**	**25 245**
Sexual/reproductive health/family planning	9 055	10 278	11 027	11 753	12 124	12 820	13 533
Family planning, direct costs	1 434	1 552	1 675	1 803	1 937	2 077	2 156
Maternal health, direct costs	2 799	3 664	4 299	5 110	6 018	7 024	8 054
Programmes and systems related costs	4 822	5 062	5 053	4 840	4 169	3 719	3 323
HIV/AIDS	7 853	10 687	10 848	11 048	11 207	11 409	11 525
Basic research/data/policy analysis	641	2 316	2 048	987	530	186	187
Latin America and Caribbean	**6 366**	**7 591**	**7 439**	**7 775**	**7 699**	**7 966**	**8 320**
Sexual/reproductive health/family planning	3 132	3 401	3 627	3 837	3 922	4 119	4 347
Family planning, direct costs	310	343	378	414	452	492	518
Maternal health, direct costs	958	1 182	1 431	1 706	2 009	2 340	2 680
Programmes and systems related costs	1 864	1 876	1 818	1 717	1 461	1 286	1 150
HIV/AIDS	3 072	3 461	3 562	3 630	3 703	3 770	3 867
Basic research/data/policy analysis	162	729	250	309	74	78	106
Western Asia and North Africa	**2 795**	**3 685**	**3 418**	**3 538**	**3 501**	**3 865**	**3 721**
Sexual/reproductive health/family planning	1 852	2 009	2 130	2 232	2 258	2 339	2 415
Family planning, direct costs	178	204	231	261	292	325	346
Maternal health, direct costs	603	735	873	1 019	1 171	1 328	1 471
Programmes and systems related costs	1 071	1 070	1 025	953	796	686	598

	2009	2010	2011	2012	2013	2014	2015
HIV/AIDS	798	1 095	1 112	1 131	1 146	1 163	1 183
Basic research/data/policy analysis	145	582	177	174	97	363	123
Eastern and Southern Europe	**2 204**	**3 091**	**3 508**	**3 226**	**3 275**	**3 326**	**3 542**
Sexual/reproductive health/family planning	933	1 137	1 334	1 510	1 645	1 824	2 004
Family planning, direct costs	91	103	116	125	135	145	146
Maternal health, direct costs	324	454	605	771	960	1 171	1 386
Programmes and systems related costs	517	579	613	614	551	508	471
HIV/AIDS	1 023	1 316	1 358	1 397	1 435	1 465	1 503
Basic research/data/policy analysis	248	638	816	320	195	38	35

Source: UNFPA, 2009, *Revised Cost Estimates for the Implementation of the Programme of Action of the International Conference on Population and Development: A Methodological Report*.

Note: UNAIDS has since updated its cost estimates for HIV/AIDS expenditures to depict a scenario that reaches coverage later than the original figures presented here. For 2009, the global figure for HIV/AIDS was $20 billion. This will increase incrementally until it reaches $37 billion in 2015, slightly higher than the original estimate.

32. The costing estimates for family planning assume that the current unmet need will be satisfied in 2015, although there is likely to be greater demand for family planning as people become more aware of the options. The costing estimates for reproductive health include antenatal care, delivery care, obstetric complications care, newborn interventions, reproductive organ cancer screening and treatment as well as other maternal care interventions. Sexually transmitted diseases/HIV/AIDS costing includes prevention, treatment, care and support, including specific elements to address issues of prevention of violence against women.

33. The cost estimates for the drugs, supplies and personnel needed to achieve the goals of the International Conference on Population and Development increase significantly over time owing to the increased number of people projected to be receiving care as service coverage is scaled up as well as to underlying population increases.

34. Health systems and programme costs related to family planning and reproductive health were estimated to reflect the need for a significant investment in the health systems and planning in order to achieve the goals of universal coverage set out at the International Conference on Population and Development. Without adequate investment in health systems and programmes, it will be impossible to achieve the coverage goals. Elements included in this cost estimation include programme management, supervision, health education, monitoring and evaluation, advocacy, health system infrastructure, information systems, human resources training and commodity supply systems. The cost estimates for health systems and programmes assume that the bulk of the investment will be made between 2009 and 2013. As a result of this assumption, cost estimates for the health systems and programmes elements peak in 2011 and then begin to decline. Cost estimates also include support during humanitarian crisis situations, which pose an ongoing challenge to medical systems in many countries.

35. It is thought that total costs for sexual/reproductive health, which includes the family planning and maternal health components (including direct costs and

programme and systems costs), will be $27.4 billion for 2010, that costs will peak at $33.3 billion in 2014, decreasing slightly, to $33 billion, in 2015. Total costs for the HIV/AIDS component are estimated to be $32.5 billion in 2010 and to increase each year thereafter, until they reach $36.2 billion in 2015.[6]

36. The estimates for the basic data, research and population and development policy analysis component were obtained by summing four expenditure categories: censuses, surveys, civil registration, and research and training. Census expenditures were based on per capita census costs by subregion, which varied from $1.50 in Eastern, Middle and northern Africa to $11.70 in Southern Europe. The total was then allocated to a four-year period: 10 per cent in the year before the census, 60 per cent in the census year, and 15 per cent in each of the two years after the census. Survey costs were estimated at $1.25 or $1.50 per household, depending on the subregion, while the household sample sizes were estimated at 1 per cent, 0.5 per cent or 0.25 per cent, depending on whether the country had less than a million, from 1 to 25 million or more than 25 million inhabitants. Furthermore, it was assumed that all developing countries should have a survey of this kind once every four years.

37. For civil registration costs, it was assumed that the cost of processing each event (births, deaths, marriages and divorces) and entering such information into the statistical system is one third of the per capita census costs for each subregion. The expenditures for research and training were computed as 5 per cent of the total average annual costs of the previous three categories over the period from 2005 to 2015. The updated cost estimates for the data and research component are considerably higher than the original estimates agreed upon in Cairo in 1994, primarily because they reflect the real costs of census-taking to a much larger degree than previously. This is especially true in 2010, when total expenditures reached $4.84 billion, of which $4.41 billion was spent on census expenditures. On the whole, census expenditures make up about three quarters (75.8 per cent) of the total, surveys 6.9 per cent, and civil registration 12.5 per cent. The average annual expenditure over the seven-year period is estimated to be $2.17 billion.

38. Current funding levels for all four categories of the costed population package are considerably below what is necessary to meet the needs in developing countries. Given the uncertainty of future funding because of the global financial crisis, full implementation of the Cairo agenda may be in jeopardy. If estimates for 2010 hold, and if donors did indeed contribute around $10.7 billion and developing countries mobilized approximately $33.7 billion in domestic resources, the total amount of $44.4 billion would, nevertheless, be roughly $20 billion short of what was needed in 2010 to finance population programmes in developing countries.

39. To ensure the implementation of the goals of the International Conference on Population and Development and the achievement of the Millennium Development Goals, it is necessary to increase both donor and domestic funding in all four components of the costed population package.

[6] UNAIDS has since updated its cost estimates for HIV/AIDS expenditures, revealing a scenario that reaches coverage later than the original figures presented in table 3. The global figure for 2009 for HIV/AIDS expenditures is $20 billion. This will increase incrementally, reaching $37 billion in 2015, slightly higher than the original figure.

VI. Major challenges in implementing the financial targets of the International Conference on Population and Development

40. **Impact of global financial crisis.** The global financial crisis continues to affect the amount of resources allocated to population activities. The rate of increase in population assistance has slowed down and a number of donors that have been particularly affected by the crisis have decreased funding levels for population. Future funding levels will very much depend on the impact of the financial crisis on both donors and developing countries.

41. **Resource mobilization is dependent on a few key players.** Population assistance originates with a few major donors and the majority of domestic resources are mobilized in a few large developing countries. Most donor countries do not provide substantial funding for population activities and most developing countries are not in a position to mobilize sufficient resources to fund much needed population and AIDS programmes. Poor countries are faced with many competing development priorities and many of them cannot afford to make the necessary investments in population.

42. **Consumer spending exceeds Government and NGO expenditures for population.** Although not easy to track, the role played by consumers in spending on family planning, reproductive health and sexually transmitted diseases/HIV/AIDS is much larger than usually assumed, and in many cases it exceeds Government and NGO expenditures. Although variations exist between regions and countries, if spending on family planning, reproductive health and sexually transmitted diseases/HIV/AIDS is in line with spending on health in general, it can be assumed that consumers in developing countries pay more than half of the burden of such expenditures. Out-of-pocket spending by consumers, especially the poor, has important implications for policy initiatives aimed at reducing poverty and income inequality in the developing world.

VII. Conclusion

A. Progress in resource mobilization

43. Considerable progress has been made and funding has increased in all four components of the population package costed under the International Conference on Population and Development. This is a most welcome development. However, the financial resources currently mobilized are still not sufficient to meet today's growing needs, and current funding levels remain below what is necessary to realize the goals of the Conference and to achieve the Millennium Development Goals. This is true for all four components of the costed population package. More donor assistance and more national investments in developing countries are needed in order to meet the growing needs and costs, especially in light of the large youth population. The lack of adequate funding remains a major impediment to the full implementation of both the goals of the Conference and the Millennium Summit.

44. According to the revised cost estimates presented to the United Nations Commission on Population and Development in 2009, a total of $65 billion was needed by 2010 in order to fully fund reproductive health services, including family planning and HIV/AIDS services, as well as censuses, surveys, civil registration and

population research and training. The international community is a long way from reaching this level. This is particularly urgent given the fact that world population has reached 7 billion. Indeed, the need for funding is now greater than ever if the international community is to meet the challenges and take advantage of the opportunities that a world of 7 billion people presents.

B. The way forward

45. Increased efforts to mobilize adequate resources on the part of both donors and developing countries are essential to fully implement the agenda of the International Conference on Population and Development. Given current needs, all Governments, of both donor and developing countries, are encouraged to recommit themselves to implementing the objectives of the International Conference and to mobilizing the resources required to meet those objectives. It is important that funding for all four population categories under the Programme of Action continue to increase.

46. To accelerate the implementation of the Cairo agenda and to achieve the Millennium Development Goals, the international community should continue to ensure that population and reproductive health are seen as an integral part of the achievement of the Goals and that they figure prominently in national development programmes and poverty reduction strategies.

47. Given the limited financial resources, it is essential that donor countries, international agencies and developing countries continue to strengthen their efforts and their collaboration to avoid duplication, identify funding gaps and ensure that resources are used as effectively and efficiently as possible. Coordinating donor financing policies and planning procedures will help to enhance the impact and cost-effectiveness of contributions to population programmes.

48. The private sector has an important role to play in the mobilization of resources for population and development, in monitoring population expenditures and in ensuring that financial targets and equity objectives are met. Civil society, especially women's NGOs, can play an important role in trying to ensure that Governments achieve financial targets and equity objectives and that resources reach all segments of the population, especially those that are most in need.

49. The price may be high, but the cost of not mobilizing adequate financial resources is much higher. It is not counted in dollars or local currencies, but in infant, child and maternal mortality, mortality due to HIV/AIDS, high adolescent fertility and unmet need for family planning. The international community cannot be complacent when levels of morbidity and mortality resulting from such causes remain unacceptably high in many parts of the world. It is especially important to ensure that the needs of the most vulnerable populations, including the growing number of young people, are met.

50. The challenge is to mobilize sufficient resources to meet growing needs. This is particularly important given the current global financial crisis. Increased political will and a re-doubling of efforts to generate additional international assistance and increased domestic funding from all sources are urgently needed to accelerate the implementation of the Programme of Action of the International Conference on Population and Development.